2700.6 Annual Report on Home and Community-Based Services Waivers (Form HCFA-372 and Form HCFA-372(S)).--

A. Legal Background and Authority for Home and Community-Based Services Waivers.--Section 2176 of Public Law 97-35, OBRA of 1981, added §1915(c) to the Act. The section authorizes the Secretary to waive certain Medicaid statutory limitations in order to allow a State to cover a broad array of home and community-based services that an individual may need in order to avoid institutionalization. Section 2176 provided that a State with an approved waiver may be reimbursed for home and community-based services provided to individuals who would otherwise require the level of care provided in a SNF or ICF, the cost of which could be paid under the State plan. Section 9502 of Public Law 99-272, COBRA of 1985, permitted States to also offer home and community-based services to ventilator-dependent individuals who require a hospital level of care. Section 9411 of Public Law 99-509, OBRA of 1986, further expanded the waiver authority by permitting States to provide Medicaid covered home and community-based services to low income individuals who, but for the provision of such services, would require Medicaid care in a hospital. Section 4211 of Public Law 100-203, OBRA of 1987, combined SNF and ICF benefits into a single nursing facility (NF) benefit effective October 1, 1990. Section 411 of Public Law 100-360, Medicare Catastrophic Coverage Act of 1988, increased the number of recipients who could be served in a model home and community-based waiver from 50 to 200. Section 8437 of Public Law 100-647, the Technical and Miscellaneous Revenue Act of 1988, removed the requirement for institutionalization prior to receiving home and community-based services under an illness or condition-specific waiver. Section 4741 of Public Law 101-508, OBRA of 1990 clarified:

- The definition of room and board (§4742 (a), (c), (d) and (e), respectively);

- That a State with a home and community-based waiver for recipients with mental retardation or a related condition, with clients in an ICF/MR terminated from the Medicaid program, could disregard the reduction in the number of beds at the facility;

- That the Secretary has no authority to limit the number of hours of respite care that a State may offer under a budget-neutral home and community-based services waiver; and

- That States with operational home and community-based waivers for individuals with mental retardation or related conditions could make adjustments in their utilization and expenditure estimates to reflect the implementation of the preadmission screening and annual resident review program (PASARR) under nursing home reform legislation (OBRA of 1987).

Once granted, waivers under §1915(c) of the Act are in effect for an initial term of 3 years and may be renewed for an additional 5-year period.

The Secretary may approve a waiver renewal if the State requests renewal, the request meets the statutory and regulatory requirements, and the Secretary determines that the State met all of the assurances for the prior waiver period. Section 1915(e) of the Act, as amended by §2175 of OBRA 1981 and redesignated as §1915(f)(1) by §411(k)(17) of the Medicare Catastrophic Coverage Act of 1988, Public law 100-360, provides that the Secretary must monitor the implementation of the waivers granted to determine if the requirements of the waivers are being met. States are required to annually

provide HCFA with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of recipients. After giving the State notice and an opportunity for a hearing, the Secretary may terminate a waiver for noncompliance with the requirements.

B. Purpose.--Forms HCFA-372 and HCFA-372(S) provide a basis for the monitoring of waivers by HCFA. The information is not used as a financial report for purposes of determining federal financial participation (FFP), but the information is auditable. The report is used by HCFA to compare actual data to the approved waiver estimates and, in conjunction with compliance review reports and Forms HCFA-2082 and HCFA-64, to determine whether to continue a home and community-based services waiver.

Form HCFA-372 was previously revised in light of the requirements of the final regulation issued March 13, 1985, and was updated to incorporate the provisions of COBRA of 1985, OBRA of 1986 and OBRA of 1987. Use Form HCFA-372 for the annual report for waiver years operating under the 14-element cost-neutrality formula.

This current update introduces the supplemental Form HCFA-372(S) and incorporates significant changes in the formula values published in a final rule on July 25, 1994 in 42 CFR 441.303. These changes became effective August 24, 1994. The revised formula simplifies the waiver cost-neutrality test and retains only formula values: D, D', G, and G'. Use Form HCFA-372(S) for the annual report on waiver years operating under the 4-element simplified cost-neutrality formula.

C. Content.--Form HCFA-372 has 9 sections that provide for annual reporting of the following information:

Section I. Annual number of institutional services recipients for level/s of care covered by the waiver.
Section II. Annual expenditures for institutional services for level/s of care covered by the waiver.
Section III. Annual number of institutional services recipients who received acute care services while institutionalized.
Section IV. Annual expenditures for acute care services to institutional services recipients.
Section V. Annual number of §1915(c) waiver recipients.
Section VI. Annual §1915(c) waiver expenditures.
Section VII. Annual number of waiver recipients who received acute care services wh in the waiver.
Section VIII. Annual expenditures for acute care services to waiver recipients.
Section IX. Other Required Data.

Form HCFA-372(S) has 5 sections that provide for annual reporting of the following information:

Section I. Annual number of §1915(c) waiver recipients.
Section II. Annual §1915(c) waiver expenditures.
Section III. Annual expenditures for all other Medicaid services provided to waiver recipients.
Section IV. Waiver cost-neutrality formula.
Section V. Other Required Data.

D. Reporting Requirements.--All State Medicaid agencies administering or supervising the administration of a home and community-based services waiver are required to submit a separate Form HCFA-372 or HCFA-372(S) for each

approved waiver. Data must be furnished on a date of service basis. Computer generated or other facsimile formats are acceptable.

The first report for each waiver must have data from the effective date (and, for subsequent reports, the anniversary of that date) of the waiver to the end of one full year thereafter. For example, if April 1, 1984 is the effective date of the waiver, provide all applicable data on a date of service basis from April 1, 1984 through March 31, 1985. Applicable date of service information for the second year would cover the period of April 1, 1985 through March 31, 1986. A separate Form HCFA-372 or Form HCFA-372(S) report is required for extension periods granted by HCFA while a waiver's renewal is pending if the extension period is not subsumed into the renewal period. You should submit a Form HCFA-372 or Form HCFA-372(S) for each extension year, plus a separate report for each additional portion of a year during which the waiver operated on a temporary extension which is not subsumed into the renewal. Similarly, if you terminate a waiver which only operated for part of a year, you must still submit a Form HCFA-372 or Form HCFA-372(S) for that portion of the year in which the waiver was in effect.

Due to the 12-month reporting cycle, there will be data not available when Forms HCFA-372 or Form HCFA-372(S) are submitted. Consequently, complete a separate lag report Form HCFA-372 or Form HCFA-372(S) to report the revised total data for the prior year. When revising previously reported Form HCFA-372 or Form HCFA-372(S) data (e.g., when submitting a "lag" report), submit a complete report except for that section of the report on health and welfare. Indicate the prior period to which the revised data apply. This lag report is due with the next year's Form HCFA-372 or Form HCFA-372(S) and no further updating of the prior year data is required. Instructions for completing a prior year lag report are furnished in item L under the heading Detailed Instructions. A lag report need not be submitted if you submit a complete initial report.

All instructions for Form HCFA-372 and Form HCFA-372(S) are also applicable to model waivers. However, a complete Form HCFA-372 is not required for model waivers. Sections V, VI, VII, VIII and IX.C and D of the form must be completed in full. The State retains the option of completing any additional portions of the form. If the State does not complete the optional sections, it must support the cost and utilization estimates with documentation of the appropriate institutional and acute care services when requesting a waiver renewal. This requires retrieval of data on these services during the waiver period prior to renewal.

On Forms HCFA-372 and Form HCFA-372(S), data on recipients is reported on the basis of annual unduplicated individuals, not cases, slots, or families. The term unduplicated refers to unduplicated counts for each value in the formula. For example, a recipient who is an inpatient in a Medicaid long term care facility for a level of care covered under the waiver on two occasions during the waiver year and who also receives waiver services during the waiver year is counted as one recipient under formula value A, and one unduplicated recipient under formula value C (and under the prime formula values, as appropriate) on Form HCFA-372. On Form HCFA-372(S) if a recipient is served under the waiver on multiple occasions during the year with an intervening period of institutionalization, he or she is only counted as one unduplicated recipient in Section I. Data on expenditures must be reported in whole dollars and must be the total computable expenditures.

E. Submittal Procedures for Due Date.--Submit the original report on new waivers for year 1, year 1 lag and year 2 for both Forms HCFA-372 and HCFA-372(S) to:

Health Care Financing Administration
Division of Benefits, Coverage and Payment
Room S2-14-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Submit the year 2 lag, year 3 initial and all other succeeding Forms HCFA-372 and HCFA-372(S) reports to the appropriate RO. You need not submit a copy of these reports to the CO. The reports must reach the RO or CO within 181 days after the last day of the waiver reporting period.

F. Burden Disclosure Notice.--The public reporting burden for this collection of information is estimated to average 90 hours for Form HCFA-372 and 80 hours for Form HCFA-372(S) per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the following offices:

Health Care Financing Administration
Office of Financial Management Services
P.O. Box 26684
Baltimore, Maryland 21207

and

Information and Regulatory Affairs
Office of Management and Budget
Washington, DC 20503.

Re: Paperwork Reduction Project No. 0938-0272

G. Effective Date.--The present version of Form HCFA-372 and the supplemental Form HCFA-372(S) may be used immediately. Form HCFA-372 must be submitted for waiver years operating under the 14-element formula. You are required to convert to the simplified formula at the time of renewal or amendment to the waiver effecting costs/utilization. Once you have converted to the simplified formula, you must submit Form HCFA-372(S). Clearance from the Executive Office of Management and Budget (EOMB) for these forms has been obtained.

H. Recipients to Report on Form HCFA-372.--The recipients and the sections in which to report them are:

- Recipients of institutional services in sections I, III, and IX; and
- Recipients of §1915(c) waived services in sections V, VII, and IX.

I. Recipients to Report on Form HCFA-372(S).--The recipients and the section in which to report them are:

- Recipients of §1915(c) waivered services in Section I.

J. Expenditures to Report on Form HCFA-372.--The expenditures and the sections in which to report them are:

- o Expenditures for institutional services in section II;
- o Expenditures for §1915(c) waived services in section VI; and
- o Expenditures for acute care services in sections IV and VIII.

K. Expenditures to Report on Form HCFA-372(S).--The expenditures and the sections in which to report them are:

- o Expenditures for §1915(c) waivered services in Section II.
- o Expenditures for all other Medicaid services for waiver recipients in Section III.

L. Detailed Instructions.--Complete the heading sections of the report by entering the name of the State, the reporting period covered by the report, the identification number assigned by HCFA at the time the waiver request was received, and the waiver title. Check the initial report or lag report, as appropriate. Additionally, complete the blank lines following the column heading "Level(s) of Care In Approved Waiver" by labeling the data columns with the level(s) of care in the approved waiver, i.e., NF, ICF/MR, inpatient hospital combined. It is unlikely that any one waiver includes more than 3 levels of care. However, if this situation occurs, use an additional Form HCFA-372 or Form HCFA-372(S) for the remaining levels of care. Be sure to include complete heading information on each form. Complete section IX.D of Form HCFA-372 and section V., Item C. on Form HCFA-372(S) only once but include information for the levels of care approved in the original waiver package.

If the waiver is targeted to persons with a particular illness or condition, such as AIDS, chronic metal illness, ventilator dependency, physical disability, etc., also indicate that targeted group on these lines, i.e., NF-physically disabled, Inpatient hospital-AIDS, etc. These labels identify the level of care related to the data reported in that column and must be shown consistently on each page of the report. On Forms HCFA-372 and HCFA-372(S), complete one column for each level of care for which cost estimates were provided in the approved waiver package. For example, if the approved waiver includes only recipients who would otherwise receive an ICF/MR level of care, label the first column of each page ICF/MR and leave the remaining two columns blank. If the approved waiver covers recipients who would otherwise receive a NF or hospital level of care, label one column NF, a second column Hospital, and leave the third column blank.

NOTE: On Form HCFA-372(S), you are not required to report separately on all levels of care. If the State chooses to report only on the combined level of care, label the first column combined level of care and leave the second and third columns blank.

As a general rule, report the data for each section of Form HCFA-372 or Form HCFA-372(S) relating to a formula factor value according to the same methodology used to estimate the respective factor values in the approved waiver package. For example, if data was used for a specific target population in the cost-neutrality test, report only targeted data on the Form HCFA-372 or Form HCFA-372(S).

M. Instructions for Completing Form HCFA-372.--Form HCFA-372 is to be used as the annual report for waiver years operating under the 14-element cost neutrality formula. If the waiver was amended during the waiver year to use the 4-element simplified formula, Form HCFA-372(S) must be used for that year.

1. Section I (Subsections A-B).--Section I reports the annual number of institutional services recipients for the level(s) of care in the approved waiver. For example, if the waiver includes only recipients who would otherwise receive an ICF/MR level of care, data on that level of care are required. Data on the hospital and NF levels of care are not required. If the waiver includes only individuals with developmental disabilities who were inpatients of a NF but in need of an ICF/MR level of care and the average per capita expenditures were estimated as if these individuals were inpatients of an ICF/MR, only data for the ICF/MR level of care are required.

NOTE: Report only data for the type of care covered by the waiver. For example, if the waiver covers the ICF/MR level of care, complete only lines A.1.a.-b. of the ICF/MR column in subsection A. For recipients receiving services at more than one of the approved waiver's levels of care during the reporting period, report data based on the level of care provided at the latter of the beginning of the waiver year or the date of first institutionalization.

To be reported as a waiver recipient, an individual must have received one or more paid services during the reporting period for which Medicaid payment is made. Report recipients accepting the waiver program who did not receive any waiver services during the reporting period but who received institutional services of the type covered under the waiver as nonwaiver recipients.

Although waivers have been approved for specific geographic localities through a waiver of statewideness, statewide data are required. The only exception to the requirement of statewide data are:

- Model waivers (for which completion of this section is optional) and

- Waivers targeted to individuals with a particular illness or condition where the estimates of average per capita expenditures for these recipients included in the approved waiver package were made separately from the expenditures for other individuals in the same facility. (Report the data in this section in the same manner as in the approved waiver package.)

Recipient data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, disallowances. Report the revised total number of institutionalized recipients in section I of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-4)--For each level of care in the approved waiver, enter the total annual number of unduplicated nonwaiver and waiver recipients who received, at any time during the reporting period, the level of care provided in a certified institution covered under the waiver. (See Appendix A, section I for definitions of the types of institutional services.) For a waiver covering the chronically mentally ill, use line A.4. to report recipients of inpatient psychiatric services (for age 21 and under) and mental hospital services (for age 65 and over) if applicable to the approved waiver.

Lines A.1.a. - A.4.b.--Enter the total number of unduplicated nonwaiver and waiver recipients, for each level of care in an approved waiver, who received services in a certified institution covered under the waiver during the reporting period.

Subsection B (Line B.1.)--Enter the total number of unduplicated institutional services recipients (the sum of lines B.1.a.-b). This number represents, for each level of care, the actual value(s) for the regulatory formula's factor A.

Lines B.1.a. - B.1.b.--Enter the total number of unduplicated nonwaiver and waiver institutional services recipients for each of the approved waiver's level(s) of care.

2. Section II (Subsections A-B)--Section II reports, for the level(s) of care in the approved waiver, the annual expenditures for institutional services for those recipients included in section I.

Expenditure data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised institutional services expenditures in section II of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-4).--For each level of care in the approved waiver, enter the total annual expenditures for each institutional service covered under the waiver and received by nonwaiver and waiver recipients during the reporting period. For a waiver covering the chronically mentally ill, use line A.4. to report expenditures for inpatient psychiatric services (for age 21 and under) and mental hospital services (for age 65 or over), if applicable to the approved waiver.

Lines A.1.a - A.4.b.--Enter the total annual expenditures for services received during the reporting period in an institution of the type covered under the waiver distributed by level of care for nonwaiver and waiver recipients.

Subsection B (Line B.1).--Enter the average per capita institutional services expenditures for all nonwaiver and waiver recipients for each level of care in the approved waiver. This number represents the actual value(s) for the regulatory formula's factor B for each of the waiver's level(s) of care. For each level of care in the approved waiver, calculate the sum of the expenditures reported in subsection A for that type of institutional care (section II, line A.1., A.2., A.3., or A.4.). Divide this sum by the total number of unduplicated recipients of these institutional services (section I, line A.1., A.2., A.3., or A.4.) for that type of care. The result is the average per capita institutional services expenditures for that level of care. Enter this result in the appropriate column of line B.1.

For example, to compute the factor B value for an ICF/MR level of care, include only expenditures for ICF/MR services. To compute the average per capita expenditures, calculate the sum of the total annual institutional services expenditures for the ICF/MR care reported in Section II, lines A.1.a.-b. and divide by the total number of unduplicated recipients of these services reported in section I, lines A.1.a.-b.

To compute the factor B values for a NF/hospital waiver, calculate the sum of the NF expenditures shown on lines A.2.a.-b. in both the NF and hospital columns of section II and divide by the total number of unduplicated recipients (shown on lines A.2.a.-b. in the NF and hospital columns of section I). The result is the average per capita NF expenditure. Repeat the process using lines A.4.a.-b. in sections I and II to calculate the average per capita hospital expenditure.

Lines B.1.a-B.1.b.--Separately enter the average per capita institutional services expenditures for the nonwaiver recipients and waiver recipients for each level of care in the approved waiver. The average expenditures are

computed by separately repeating the procedures used to calculate the average expenditures entered in section II, line B.1 for nonwaiver and waiver recipients.

3. Section III (Subsections A-B).--Section III reports, for the level(s) of care in the approved waiver, the annual number of institutional services recipients from section I who received any of the acute care services while institutionalized otherwise provided under the State plan. For the purposes of the regulatory equation and Form HCFA-372 reporting, acute care services are defined as all services otherwise provided under the State plan that are not included in formula factor B as hospital, NF, or ICF/MR services nor in the estimated formula factor I as nonistitutional long term care services. (See Appendix A, section IV for definitions of types of noninstitutional, long term care services.) Acute care services recipient data are required for each institutional services recipient included in section I from the latter of the date of institutionalization or the beginning of the waiver year until the recipient is discharged to home or for waiver program enrollment. For recipients receiving services at more than one of the approved waiver's levels of care, report data based on the level of care on the first day of long term care institutionalization or, if later, the beginning of the waiver year. Recipient data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, disallowances. Report the revised total number of institutional services recipients who received acute care services in section III of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-6).--Enter the total annual number of unduplicated nonwaiver and waiver recipients who received, during the reporting period, the level of care covered under the waiver and any of the acute care services otherwise provided under the State plan during the period from institutionalization to final discharge to home or to the waiver. (See Appendix A, section II for the definitions of the types of acute care services.)

Lines A.1.a.-A.6.b.--Enter the number of unduplicated nonwaiver and waiver services recipients who received each acute care service for each level of care in the approved waiver.

Subsection B (Line B.1).--Enter the total number of unduplicated institutional and acute care services recipients (the sum of lines B.1.a.-b.). This number represents, for each level of care in the approved waiver, the actual value(s) for the regulatory formula's factor A'.

Lines B.1.a.-B.1.b.--Enter the total number of unduplicated nonwaiver and waiver recipients for each level of care in the approved waiver, who received institutional and acute care services during the reporting period (the period specified in item 3).

4. Section IV (Subsections A-B).--Section IV reports, for the level(s) of care in the approved waiver, the annual expenditures for the acute care services provided to the recipients included in section III.

Expenditure data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised expenditures for acute care services provided to institutional services recipients in section IV of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-6).--Enter the total annual expenditures for the acute care services provided to the nonwaiver and waiver institutional services recipients during the period specified in item 3 (section III above) distributed by level of care. Also, enter the total of these expenditures for each column on line A.

Lines A.1.a.-A.6.b.--Enter the total expenditures for each acute care service distributed by level of care for nonwaiver and waiver recipients.

Subsection B (Line B.1).--Enter the average per capita expenditures for acute care services provided to the total number of nonwaiver and waiver institutional services recipients (section III) for each level of care (columns 1-3) in the approved waiver during the period specified in item 3.

This number represents, for each level of care in the approved waiver, the actual value(s) for the regulatory formula's factor B'. To compute the average per capita expenditures for each level of care in the approved waiver, calculate the sum of the annual expenditures for acute care services (section IV, lines A.1.a.-A.6.b.) for each column. Divide this sum by the total number of unduplicated recipients of these services reported in section III, line B.1. for that level of care. The result is the average per capita expenditures for acute care services to institutional services recipients for each level of care in the approved waiver.

Lines B.1.a.-B.1.b.--Separately enter the average per capita expenditures for acute care services to the nonwaiver institutional services recipients and waiver institutional services recipients for each level of care (columns 1-3) in the approved waiver. Compute the average expenditures by separately repeating the procedures used to calculate the average expenditures entered in section IV, line B.1.

5. Section V (Subsections A-B).--Section V reports, for the level(s) of care in the approved waiver, the annual number of §1915(c) home and community-based waiver services recipients. To be reported as a waiver recipient, the individual must have received a paid waiver service during the reporting period. For recipients receiving services at more than one of the approved waiver's levels of care, report data based on the level of care at the later of the beginning of the waiver year or the recipient's waiver program enrollment.

Recipient data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, disallowances. Report the revised total number of waiver services recipients in section V on a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-8).--Enter the total annual number of waiver recipients who received each approved §1915(c) home and community-based waiver service during the reporting period, distributed by level of care. (See Appendix A, section III for the list of 1915(c) services.)

Lines A.1. - A.8.--Specify each service as it is described in the approved waiver and enter the number of unduplicated waiver recipients who received each waiver service for each level of care in the approved waiver.

Subsection B (Line B.1).--Enter the total number of unduplicated waiver services recipients (the sum of lines B.1.a.-b.). This number represents, for each level of care in the approved waiver, the actual value/s of the regulatory formula's factor C.

Lines B.1.a.-B.1.b.--Separately enter the total number of unduplicated deinstitutionalized and diverted §1915(c) home and community-based waiver recipients for each level of care in the approved waiver. Deinstitutionalized waiver recipients refer to individuals who were receiving hospital services of a type covered under the waiver or who were in a NF or ICF/MR and were deinstitutionalized because of waiver program enrollment. These include hospitalized recipients who were in a long term care facility immediately prior to inpatient hospitalization and who would have returned to the long term care facility in the absence of the waiver. Diverted waiver recipients refer to individuals who were not deinstitutionalized.

6. Section VI (Subsections A-B).--Section VI reports, for the level/s of care in the approved waiver, the annual expenditures for the §1915(c) home and community-based waiver services.

Expenditure data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, disallowances. Report the revised expenditures for home and community-based waiver services in section VI of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-8).--Enter the actual annual Medicaid expenditures for each approved home and community-based waiver service received by the waiver recipients during the reporting period by level of care. Also enter the total of these expenditures for each column on line A.

Lines A.1. - A.8.--Specify each service as it is described in the approved waiver and enter the total expenditures for each waiver service distributed by level of care for the waiver recipients.

Subsection B (Line B.1).--Enter the average per capita expenditures for §1915(c) home and community-based services provided to the total number of deinstitutionalized and diverted waiver recipients (section V) for each level of care (columns 1-3) in the approved waiver. This number represents, for each level of care in the approved waiver, the actual value/s for the regulatory formula's factor D. To compute the average per capita expenditures for each level of care in the approved waiver, calculate the sum of the annual expenditures for HCFA approved §1915(c) waiver services (section VI, lines A.1.-A.8.) for each column. Divide this sum by the total number of unduplicated recipients of these services reported in section V, line B.1. for that level of care. The result is the average per capita expenditures for HCFA approved §1915(c) waiver services to deinstitutionalized and diverted waiver recipients.

Lines B.1.a-B.1.b.--Separately enter the average per capita §1915(c) home and community-based waiver services expenditures for services provided to deinstitutionalized waiver recipients and diverted waiver recipients at each level of care (columns 1-3) in the approved waiver. The average expenditures are computed by separately repeating the procedures used to calculate the average expenditures entered in section VI, line B.1.

7. Section VII (Subsections A-B).--Section VII reports, for the level's of care in the approved waiver, the annual number of §1915(c) home and community-based waiver recipients who received any of the acute care services otherwise provided under the State plan while in the waiver. For the purposes of the regulatory equation and Form HCFA-372 reporting, acute care services are all services otherwise provided under the State plan including home health, personal care and adult day health formerly reported as factor H that are not included in formula factor B as hospital, NF, or ICF/MR services. (See Appendix A, section IV for definitions of the types of noninstitutional, long-term care services.) Acute care services recipient data are required for each waiver recipient included in section V from the time of the receipt of the first waiver service in the waiver year until waiver program enrollment termination or at the end of the waiver year.

For recipients receiving services at more than one of the approved waiver's levels of care, data are reported based on the level of care at the later of the beginning of the waiver year or the waiver program enrollment date.

Recipients data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report in section VII of a separate lag report the revised total number of waiver recipients who received acute care services. Indicate the prior period to which the revised data apply. Do not combine current and revised data in a single report.

Subsection A (Lines 1-6).--Enter the total number of unduplicated §1915(c) waiver recipients distributed by level of care who, for the period specified in item 7, received any of the acute care services otherwise provided under the State plan during the reporting period. (See Appendix A, section II for the definitions of the types of the acute care services.) Include on line A.6. the number of waiver recipients who received home health, personal care, or adult day health services.

Lines A.1.-A.6.--Enter the number of unduplicated waiver recipients who received each acute care service for each level of care in the approved waiver.

Subsection B (line B.1).--Enter the total number of unduplicated diverted and deinstitutionalized waiver/acute care services recipients (the sum of lines B.1.a.-b.). This number represents, for each level of care in the approved waiver, the actual value/s for the regulatory formula's factor C'.

Lines B.1.a-B.1.b.--Separately enter for each level of care in the approved waiver the total number of unduplicated deinstitutionalized waiver recipients and diverted waiver recipients who, for the period specified in item 7 (section VII above), received acute care services during the reporting period.

8. Section VIII (Subsections A-B).--Section VIII reports, for the level/s of care in the approved waiver, the annual expenditures for the acute care services provided to the recipients included in section VII.

Expenditure data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised expenditures for acute care services provided to the waiver recipients in section VIII of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior data in a single report.

Subsection A (Lines 1-6).--Enter the total annual expenditures for acute care services provided during the period specified in item 7 to the §1915(c) waiver recipients distributed by level of care. Also, enter the total of all expenditures for each column on line A.

Line A.1.-A.6.--Enter the total expenditures for each acute care service distributed by level of care.

Subsection B (Line B.1).--Enter the average per capita expenditures for acute care services provided during the period specified in item 7 to the total deinstitutionalized and diverted waiver/acute care services recipients (section VII) for each level of care (columns 1-3) in the approved waiver. This number represents, for each level of care in the approved waiver, the actual value/s for the regulatory formula's factor D'. To compute the average per capita expenditures for each level of care in the approved waiver, calculate the sum of the annual expenditures for acute care services (section VIII, line A.1.-A.6.) for each column. Divide this sum by the total number of unduplicated recipients of these services reported in section VII, line B.1. for that level of care. The result is the average per capita expenditures for acute care services to §1915(c) waiver recipients.

Lines B.1.a.-B.1.b.--Separately enter the average per capita expenditures for acute care services provided during the period specified in item 7 to deinstitutionalized waiver recipients and diverted waiver recipients at each level of care (columns 1-3) in the approved waiver. Compute the average expenditures by separately repeating the procedures used to calculate the average expenditures entered in section VIII, line B.1.

9. Section IX (subsections A-D.--Section IX reports other required data.

Subsection A (Lines 1-2).--Enter the total days of waiver coverage for deinstitutionalized and diverted waiver recipients for each level of care in the approved waiver. To be counted as a waiver recipient, an individual must have received one or more paid waiver services during the reporting period.

Include in these data all days as follows:

- Begin with the later of:
  - The first day of waiver enrollment; or
  - The first day of the reporting period.
- End with the earlier of:
  - The last day of waiver program enrollment; or
  - The last day of the reporting period.

This data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised total data in section IX of a separate lag report. Indicate the prior period to which the revised data apple. Do not combine current and revised prior period data in a single report.

Subsection B (Lines 1-2).--Enter the total days of institutional care for nonwaiver and waiver recipients by level of care.

Include in these data all days as follows:

- o Begin with the latter of:
  - The first day of institutionalization; or
  - The first day of the reporting period.
- o End with the earlier of:
  - The day of discharge to home or the waiver program; or
  - The last day of the reporting period.

This data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised total data in section IX of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection C.--A lag report is not required if the State submits a complete initial report. If all data for that particular year is included on the initial Form HCFA-372, indicate that Form HCFA-372 is a complete report and thus a lag report would not be necessary. However, it is important to note that failure to submit timely Form HCFA-372 reports can result in a delay in approval of a State's amendment or renewal request.

Subsection D.--Check the appropriate boxes regarding the impact of the waiver on the health and welfare of waiver recipients and include the attachments indicated. If item 4 is not checked, then both items 5 and 6 must be checked and addressed. All other items must always be checked and the specified information provided in order for this section to be acceptable.

10. Certification.--

o Signature: The individual in the State Medicaid agency who is certifying the information contained in this report.

o Title: The official title of the above individual.

o Date: Date the information is forwarded to HCFA.

o Contact Person: Enter the name of the individual to whom questions regarding this report should be addressed.

o Telephone Number: Enter the telephone number including the area code of the contact person.

EXHIBIT A

Annual Report on Home and Community-Based Services Waivers

Pages 2-244 thru 2-248 are reserved

N. Instructions for Completing Form HCFA-372(S).--Form HCFA-372(S) is to be used for waiver years operating under the 4-element simplified cost-neutrality formula. If the waiver was amended during the waiver year using the 4-element simplified formula, Form HCFA-372(S) must be used for that year.

NOTE: While not required on Form HCFA-372(S), documentation must be provided to support factor G (the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted) and factor G' (the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted), at the time of renewals, as well as for amendments, and to substantiate any questions that may arise concerning the cost-neutrality of the waiver program as reported on Form HCFA-372(S).

1. Section I (Subsection A-B).--Section I reports, for the level(s) of care in the approved waiver, the annual number of unduplicated Medicaid recipients receiving §1915(c) home and community-based waiver services. To be reported as a waiver recipient, the individual must have received a waiver service during the reporting period for which Medicaid payment was made.

For recipients receiving waiver services at more that one of the approved waiver's levels of care, report data based on the level of care at the latter of either the beginning of the waiver year or the recipient's waiver program enrollment. Recipient data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised total number of waiver services recipients in section I of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-8).--Enter the total number of unduplicated waiver recipients who received each approved §1915(c) home and community-based waiver service during the reporting period by level of care. (See Appendix B, section I for the list of the §1915(c) services.)

Lines A.1. - A.8.--Specify each service as it is described in the approved waiver, and enter the number of unduplicated waiver recipients who received each waiver service by level of care in the approved waiver.

Subsection B (Line B.1).--Enter the total number of unduplicated waiver services recipients. This number represents, by level of care in the approved waiver, the number of unduplicated recipients receiving waiver services (formerly formula value C).

2. Section II (Subsection A).--Section II reports, for the level(s) of care in the approved waiver, the annual expenditures for the §1915(c) home and community-based waiver services.

Expenditure data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised expenditures for home and community-based services provided to the waiver recipients in section II of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection A (Lines 1-8).--Enter the actual annual Medicaid expenditures for each approved home and community-based waiver service received by waiver recipients during the reporting period by level of care. Also, enter the total amount of these expenditures for each column on line A.

Lines A.1. - A.8.--Specify each service as it is described in the approved waiver and enter the total expenditures for each waiver service by level of care for the waiver recipients.

Subsection B (Lines B.1).--Enter the average per capita annual expenditure for §1915(c) home and community-based services provided to the total number of waiver recipients (section I) for each level of care (columns 1-3) in the approved waiver. This number represents, for each level of care in the approved waiver, the actual value(s) for the regulatory formula's factor D.

To compute the average per capita expenditures for each level of care in the approved waiver, calculate the sum of the annual expenditures for HCFA-approved §1915(c) waiver services (section II, lines A.1.-A.8.) for each column. Divide this sum by the total number of unduplicated recipients of these services reported in section I, line B.1. for that level of care. The result is the average per capita expenditures for HCFA-approved §1915(c) waiver services to waiver recipients.

3. Section III.--Section III reports, for the levels of care in the approved waiver, the average per capita annual expenditures for all other Medicaid services for which Medicaid payment was made for recipients during the time they were on the waiver. This would include State plan services and expanded early and periodic screening, diagnostic and treatment (EPSDT) services not included in the State plan. This redefined factor D' includes all other Medicaid costs not included in factor D; some of these costs may have been captured in factor B' and/or factor I under the 14-element formula in the past.

Institutional costs in a waiver year for recipients in the institution before they enter the waiver are not included in the computation of factor D'. If an individual is in the waiver and during the waiver year enters an institution and subsequently returns to the waiver in that waiver year, those institutional costs must be included in factor D'. If an individual is in the waiver and during the same year enters an institution but does not return to the waiver during that waiver year, those institutional costs would not be included in factor D' because the recipient is no longer in the waiver. To compute the average per capita expenditures for all other Medicaid services provided to waiver recipients by level of care in the approved waiver, divide the sum of the total expenditures for all other Medicaid services provided to waiver recipients for each level of care by the number of unduplicated recipients receiving State plan services while in the waiver (formerly factor C'). This number represents, for each level of care in the approved waiver, the actual value/s for the regulatory formula's factor D'. (The D' value shown in section IV should be a weighted average for waivers with more than one level of care.

Expenditure data may require updating to reflect lag data or adjustments e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised expenditures for acute care services provided to the waiver recipients in section III of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

4. Section IV.--Section IV requires the computation of the simplified §1915(c) waiver cost-neutrality formula to verify the cost-neutrality of the waiver program. The waiver program is cost-neutral if the average per capita annual Medicaid expenditure with the waiver in place does not exceed the average per capita annual Medicaid expenditure without the waiver. The simplified cost-neutrality formula is:

$$D + D' \leq G + G'$$

D = The estimated annual average per capita Medicaid cost for home and community-based services for recipients in the waiver program

D' = The estimated annual average per capita Medicaid cost for all other services provided to recipients in the waiver program.

G = The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for recipients served in the waiver, were the waiver not granted.

G' = The estimated annual average per capita Medicaid costs for all services other than those included in factor G for recipients served in the waiver, were the waiver not granted.

To compute the cost-neutrality formula, insert the actual D (section II.B.1.) and actual D' (section III.) on Form HCFA-372(S) in the left-hand side of the formula. Insert the approved G and G' for the year covered by your report from your approved waiver in the right-hand side of the formula. Complete the computation to ensure that the sum of D + D' is less than or equal to the estimated sum of G + G' in the approved waiver request. If, after completing the computation, the waiver is not cost-neutral, attach an explanation to Form HCFA-372(S) explaining why the waiver failed to demonstrate cost neutrality. You must then take action to amend its waiver for future years, and immediately correct the problem or the waiver may be terminated by HCFA. (See 42 CFR 441.304(d).) If a lag report is submitted, this section must also be completed.

5. Section V (Subsections A-C).--Section V reports other required data.

Subsection A.--Enter the total days of waivered coverage for all waiver individuals for each level of care in the approved waiver on line A.1. Compute the average length of stay by dividing the total days for each level of care by the number of waiver recipients for the level of care shown on line B.1. of section I. Enter the average length of stay for each level of care on line A.2. To be counted as a waiver recipient, an individual must have received one or more paid waiver services during the reporting period.

Include in these data all days as follows:

- Begin with the later of:
  - The first day of waiver enrollment; or
  - The first day of the reporting period.
- End with the earlier of:
  - The last day of waiver program enrollment; or
  - The last day of the reporting period.

This data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised expenditures for acute care services provided to the waiver individuals in section V of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection B.-- A lag report is not required if you submit a complete initial report. If all data for that particular year is included on the initial Form HCFA-372(S), indicate that Form HCFA-372(S) is a complete report and thus no lag report is necessary. However, it is important to note that failure to submit timely Form HCFA-372(S) reports can result in a delay in approval of a State's amendment or renewal request.

Subsection C.--Check the appropriate boxes regarding the impact of the waiver on the health and welfare of waiver recipients and include the attachments indicated. If item 4 is not checked, items 5 and 6 must be checked and addressed. All other items must be checked and the specified information provided for acceptance of this section.

6. Certification.--

o Signature: The individual in the State Medicaid agency who is certifying the information contained in this report.

o Title: The official title of the above individual.

o Date: Date the information is forwarded to HCFA.

o Contact Person: Enter the name of the individual to whom questions regarding this report should be addressed.

o Telephone Number: Enter the telephone number including the area code of the contact person.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0272. The time required to complete collecting this information is estimated to average 80 hours per response. This includes the time to review instructions, search existing data resources, gather the data needed, and to complete and review the information collected. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Health Care Financing Administration, P.O. Box 26684, Baltimore, Maryland 21207, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

EXHIBIT B

Annual Report on Home and Community-Based Services Waivers

Pages 2-253 thru 2-255 are reserved

Appendix A
Definitions of Types of Services

Many of the following definitions are adaptations of those given in the Code of Federal Regulations. The abbreviated definitions are intended to facilitate the classification of medical services for reporting purposes. They do not modify any requirements of the Act or supersede in any way the definitions included in the Code of Federal Regulations.

I. Institutional Services

ICF Services For Mentally Retarded - 42 CFR 440.150(c)

These may include services provided in an institution for the mentally retarded or persons with related conditions if:

o The primary purpose of the institution is to provide health or rehabilitative services to such individuals;

o The institution meets the standards in 42 CFR 443.75(b) (Intermediate Care Facility Requirements; All Facilities) and 42 CFR 483, Subpart D (Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded); and

o The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 483.440.

NF Services - §1919(a) of the Act

These are services provided in a facility that:

o Is primarily engaged in providing to residents:

- Skilled nursing care and related services for residents who require medical or nursing care,

- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

- On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and

- Is not primarily for the care and treatment of mental diseases;

o Has in effect a transfer agreement (meeting the requirements of §1861(l) of the Act, with one or more hospitals having agreements in effect under §1866; and

o Meets the requirements for a nursing facility described in §1919(b), (c) and (d) of the Act.

Such term also includes any facility which is located in a State or on an Indian reservation and is certified by the Secretary as meeting the requirements of §1919(a)(1), and §1919 (b), (c), and (d) of the Act.

Mental Health NF Services for the Aged - 42 CFR 440.140(b) and (c)

These are services defined in 42 CFR 440.40(a) and in 42 CFR 440.150 and which are provided in an institution for mental disease to recipients determined to be in need of such services.

| Hospital Services (other than services in an institution for mental diseases)-42 CFR 440.10

| These are services that are:

| o Ordinarily furnished in a hospital for the care and treatment of inpatients;

| o Furnished under the direction of a physician or dentist (except in the case of nurse midwife services per 42 CFR 440.165); and

| o Furnished in an institution that:

- Is maintained primarily for the care and treatment of patients with disorders other than mental disease;

- Is licensed and formally approved as a hospital by an officially designated authority for State standard setting;

- Meets the requirements for participation in Medicare (again, except in the case of medical supervision of nurse midwife services per 42 CFR 440.165); and

- Has in effect a utilization review plan (that meets the requirements in 42 CFR 482.30) applicable to all Medicaid patients, unless a waiver has been granted by the Secretary.

| NOTE: Inpatient hospital services do not include NF services furnished by a hospital with a swing bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separate from the general hospital.

| II. Acute Care Services - These are all services otherwise provided under the State plan that are | neither included in formula factor B as hospital, NF, or ICF/MR institutional services nor in formula factor I as the noninstitutional, long term care services provided as an alternative to long term care. (See 42 CFR 441.303.)

| Acute Inpatient Hospital Services (other than services in an institution for mental diseases) - 42 CFR 440.10

These are services that are:

o Ordinarily furnished in a hospital for the care and treatment of inpatients;

o Furnished under the direction of a physician or dentist (except in the case of nurse midwife services per 42 CFR 440.165); and

o Furnished in an institution that:

- Is maintained primarily for the care and treatment of patients with disorders other than mental disease;

- Is licensed and formally approved as a hospital by an officially designated authority for State standard setting;

- Meets the requirements for participation in Medicare (again, except in the case of medical supervision of nurse midwife services per 42 CFR 440.165); and

- Has in effect a utilization review plan (that meets the requirements in 42 CFR 482.30) applicable to all Medicaid patients, unless a waiver has been granted by the Secretary.

NOTE: Inpatient hospital services do not include NF services furnished by a hospital with a swing bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separate from the general hospital.

Physician's Services - 42 CFR 440.50

These are services furnished in the office, the recipient's home, a hospital, a NF, or elsewhere, and which are provided:

o Within the scope of practice of medicine or osteopathy as defined by State law; and

o By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

NOTE: For statistical purposes, exclude all such services that are provided by and billed for by the hospital, clinic, or laboratory. Include services provided by and billed by a physician under physician services with the exception of lab and X-ray services. Include such services provided by and billed for by a physician under the lab and X-ray services category.

Outpatient Hospital Services - 42 CFR 440.20(a)

These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

o Are furnished to outpatients;

o Except in the case of nurse midwife services (see 42 CFR 440.165), are furnished by or under the direction of a physician or dentist; and

o Are furnished by an institution that:

- Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and

- Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165) meets the requirements for participation in Medicare.

Clinic Services - 42 CFR 440.90

These are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

o Are provided to outpatients;

o Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. It may be a group of physicians who share space, services of support staff, etc., for mutual convenience only. They are considered physicians for reporting purposes, rather than a clinic, even though they practice under the name of clinic; and

o Except in the case of nurse midwife services (see 42 CFR 440.165), are furnished by or under the direction of a physician.

NOTE: Place dental clinics under all other acute care services. A clinic staff may include practitioners with different specialties.

Laboratory and X-ray Services - 42 CFR 440.30

These are professional or technical laboratory and radiological services:

o Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of his/her practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory;

o Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and

o Provided by a laboratory that meets the requirements for participation in Medicare.

NOTE: Report X-rays by dentists under the all other acute care services category.

Prescribed Drugs - 42 CFR 440.120(a)

These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

o Prescribed by a physician or other licensed practitioner within the scope of his/her professional practice as defined and limited by Federal and State law;

o Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

o Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

NOTE: For statistical reporting purposes, prescribed drugs are those dispensed by licensed pharmacists only.

All Other Acute Care Services

Dental Services - 42 CFR 440.100

These are services that are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his/her profession, including treatment of:

o The teeth and associated structures of the oral cavity; and

o Disease, injury or an impairment that may affect the oral or general health of that recipient.

A dentist is an individual licensed to practice dentistry or dental surgery.

NOTE: For statistical purposes, exclude all services provided as part of inpatient hospital, outpatient hospital, clinic or laboratory services and billed for by the hospital, non-dental clinic, or laboratory. Include dental screening and dental clinics as dental services.

Other Licensed Practitioners' Services - 42 CFR 440.60

These are any medical or remedial care or service:

o Other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. Examples of other practitioners (if covered under State law) include:

- Chiropractors;
- Professional nurses;
- Podiatrists;
- Psychologists;
- Optometrists;
- Christian Science Practitioners, and

o With certain exceptions:

- Services of professional nurses include private duty nursing services as defined in 42 CFR 440.80 when recognized in the State plan;

- If services of other practitioners are billed by a hospital, consider them as inpatient or outpatient services, as applicable;

- If eyeglasses or hearing aids are billed by a physician, include them under physician services; otherwise, include them under all other acute care services.

- Include speech therapists, audiologists, opticians, physical therapists and occupational therapists under all other acute care.

NOTE: Chiropractor services include only services provided by a chiropractor (who is licensed by the State and meets standards issued by the Secretary in 42 CFR 405.232(b)) and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

Family Planning Services - 42 CFR 440.40(c)

These include:

o Consultation (including counseling and patient education), examination, and treatment, furnished by, or under, the supervision of a physician or prescribed by a physician;

o Laboratory examination;

o Medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception;

o Natural family planning methods;

- o Diagnosis and treatment for infertility; and
- o Voluntary sterilizations and drugs.

NOTE: This includes only services matched at 90%.

Early and Periodic Screening - 42 CFR 440.40(b)

These include the physical and mental assessment given to Medicaid eligibles under the age of 21 to carry out the screening provisions of the EPSDT program.

However, the agency must provide for at least the following services through consultation with health experts, and must determine the specific health evaluation procedures to use and the mechanisms needed to carry out the screening program:

- o Health and developmental history;
- o Unclothed physical examination;
- o Developmental assessment;
- o Immunizations which are appropriate for age and health history;
- o Assessment of nutritional status;
- o Vision testing;
- o Hearing testing;
- o Laboratory procedures appropriate for age and population groups; and
- o For children 3 years of age and over, dental services furnished by direct referral to a dentist for diagnosis and treatment.

The above assessments may be done on a group basis in a clinic or by individual practitioners in their office.

Other Care - 42 CFR 440.170

This is any medical or remedial care recognized under State law and specified by the Secretary. Such services do not meet the definition of and are not classifiable under any of the aforementioned 42 CFR 440 categories. They may include, but are not limited to:

A. Transportation which includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined above, is furnished only by providers to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation (see 42 CFR 431.53), FFP is available as an administrative cost.

B. Physical Therapy which means services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. (See 42 CFR 440.110(a)(2).) It includes any necessary supplies and equipment.

C. Occupational Therapy which means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist. (See 42 CFR 440.110(b)(2).) It includes any necessary supplies and equipment.

D. Services for Individuals with Speech, Hearing, and Language Disorders (also see Other Licensed Practitioners Services) which mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist (see 42 CFR 440.110(c)(2)), for which a patient is referred by a physician. It includes any necessary supplies and equipment.

E. Dentures, Prosthetic Devices, and Eyeglasses (also see Other Licensed Practitioners Services).--

o Dentures mean artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth. (See 42 CFR 440.120(b).)

o Prosthetic devices mean replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law to;

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunctions; or
- Support a weak or deformed portion of the body.

NOTE: Include all durable medical equipment under this category.

o Eyeglasses mean lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye, an optometrist or an optician. Also includes optician fees for services. (See 42 CFR 440.120(d).)

F. Diagnostic, Screening, Preventive and Rehabilitative Services.--

o Diagnostic services, except as otherwise provided in 42 CFR 440, include any medical procedures or supplies recommended by a physician or other licensed practitioner within the scope of his or her practice under State law, in order to identify the existence, nature or extent of illness, injury, or other health deviation in a recipient. (See 42 CFR 440.130(a).)

o Screening services mean the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, or to identify for more definitive studies individuals suspected of having certain diseases. (See 42 CFR 440.130(b).)

o Preventive services mean services provided by a physician or other licensed practitioner within the scope of his or her practice under State law to:

- Prevent disease, disability, and other health conditions or their progression;
- Prolong life; and
- Promote physical and mental health and efficiency.

o Rehabilitative services, except as otherwise provided in 42 CFR 440, include any medical or remedial services recommended by a physician or other licensed practitioner, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level. (See 42 CFR 440.130(d).)

NOTE: Include nurse midwife services under inpatient hospital, outpatient hospital, or all other acute care depending upon how the services were billed. Also include emergency hospital services under various reporting categories depending upon how the services were billed.

G. Rural Health Clinic Services - 42 CFR 440.20(b).--

If you permit the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic services are the following services when furnished by a rural health clinic that has been certified in accordance with the conditions of 42 CFR 491:

o Services furnished by a physician within the scope of his/her profession under State law, if the physician performs these services in the clinic or the services are furnished away from the clinic and the physician has an agreement with the clinic providing that he or she will be paid by it for such services.

o Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 42 CFR 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2414(a).

o Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 42 CFR 405.2415 for the criteria to determine whether services and supplies are included here.)

o Part time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

- The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies. (See 42 CFR 405.2417);

- The services are furnished by an RN or LPN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic;

- The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

- The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient is one who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. He/she may be considered homebound if he/she leaves the place of residency infrequently. For this purpose, place of residence does not include a hospital or an NF.

H. Mental Hospital Services for the Aged refer to inpatient hospital services for individuals aged 65 or older, provided under the direction of a

physician for the care and treatment of recipients in an institution for mental diseases that meets the requirements specified in 42 CFR 482.60(b), (c), and(e), and meets the requirements for utilization review in 42 CFR 482.30(a), (b), (d), and (e), or has been granted a waiver of those requirements. (See 42 CFR 440.140(a).)

I. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under (see 42 CFR 440.160) are those services that:

- o Are provided under the direction of a physician;
- o Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Hospitals; and
- o Meet the requirements set in 42 CFR 441 (d) (Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs).

J. Optional Targeted Case Management Services are services provided under §1915(g)(1) of the Act to assist individuals eligible for Medicaid in gaining access to needed medical, social, educational, and other services, to encourage the use of cost effective medical care by referrals to appropriate providers, and to discourage overutilization of costly services, such as emergency room care for routine procedures.

NOTE: Case management may also be provided as a home and community-based waiver service or as an integral part of an otherwise covered Medicaid service.

III. Section 1915(c) Services - These are home and community-based services not otherwise furnished under the State plan and which are are furnished under a waiver granted under the provisions of §1915(c) of the Act. (See 42 CFR 440.180.)

NOTE: The services are not defined in the regulation but rather by the State in the waiver request. The following is a list provided to facilitate the classification of the waiver services for reporting purposes:

- o Case management services,
- o Homemaker services,
- o Home health aide services,
- o Personal care services,
- o Adult day health services,
- o Habilitation services,
- o Respite care services,
- o Day treatment or other partial hospitalization services,
- o Psychosocial rehabilitation services,
- o Clinic services for the chronically mentally ill, and
- o Other HCFA approved services.

Include services necessary to avoid recipient institutionalization which were approved as cost effective by HCFA. These include but are not limited to nursing care, medical equipment and supplies, physical and occupational therapy, speech pathology and audiology, and minor physical adaptations to the home.

IV. Noninstitutional Long Term Care State Plan Services

These are noninstitutional, long term care services otherwise provided under the State plan as an alternative to institutional care.

NOTE: These services may also be provided under a home and community-based waiver and reported in the §1915(c) services category.

Adult Day Health Services

These include health and social services needed to insure the recipient's optimal functioning.

| Home Health Services - 42 CFR 440.70

These include the following services and items:

o Nursing service, as defined in the State Nurse Practice Act, that is provided on a part time or intermittent basis by a HHA that meets the requirements for participation in Medicare or if there is no agency in the area, is provided by a registered nurse who:

- Is currently licensed to practice in the State;
- Receives written orders from the patient's physician;
- Documents the care and services provided; and
- Has had orientation on acceptable clinical and administrative recordkeeping from a health department nurse.

o Home health aide services provided by a home health agency,

o Medical supplies, equipment, and appliances suitable for use in the home, and

o Physical therapy, occupational therapy, or speech pathology and audiology services provided by a HHA or by a facility licensed by the State to provide medical rehabilitation services. (See 42 CFR 441.15 - Home Health Services.)

These services are provided to a recipient:

o At his or her place of residence (does not include a hospital, NF, or ICF except for home health services in an ICF that are not required to be provided by the facility under 42 CFR 442 (f) and (g). For example, an RN may provide short term care for a recipient in an ICF during an acute illness to avoid the recipient's transfer to an SNF; and

o On his/her physician's orders, as part of a written plan of care, that the physician reviews every 60 days.

NOTE: The Form HCFA-2082 home health category includes home health services, personal care services and home and community-based waiver services. For Form HCFA-372 reporting, only State plan provided home health services are included here.

| Personal Care Services - 42 CFR 440.170(f)

These are services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is:

- Qualified to provide the services;
- Supervised by a registered nurse; and
- Not a member of the recipient's family.

Appendix B
Definitions of Types of Services - FORM HCFA-372(S)

Many of the following definitions are adaptations of those given in the Code of Federal Regulations (CFR). The abbreviated definitions are intended to facilitate the classification of medical services for reporting purposes. They do not modify any requirements of the Act or supersede in any way the definitions included in the CFR.

I. Section 1915(c) Services.--These are home and community-based services not otherwise furnished under the State plan and which are furnished under a waiver granted under the provisions of §1915(c) of the Act. (See 42 CFR 440.180.)

NOTE: The services are not defined in the regulation but rather by the State in the waiver request. The following is a list provided to facilitate the classification of the waiver services for reporting purposes:

- o Case management services;
- o Homemaker services;
- o Home health aide services;
- o Personal care services;
- o Adult day health services;
- o Habilitation services;
- o Respite care services;
- o Day treatment or other partial hospitalization services;
- o Psychosocial rehabilitation services;
- o Clinic services for the chronically mentally ill; and
- o Other HCFA approved services.

Include services necessary to avoid recipient institutionalization which were approved as cost effective by HCFA. These include but are not limited to nursing care, medical equipment and supplies, physical and occupational therapy, speech pathology and audiology, and minor physical adaptations to the home.

II. Acute Care Services.--These are all services otherwise provided under the State plan to individuals on the waiver. (See 42 CFR 441.303.)

Acute Inpatient Hospital Services (other than services in an institution for mental diseases) - 42 CFR 440.10

These are services that are:

- o Ordinarily furnished in a hospital for the care and treatment of inpatients;
- o Furnished under the direction of a physician or dentist (except in the case of nurse midwife services per 42 CFR 440.165); and
- o Furnished in an institution that:

- Is maintained primarily for the care and treatment of patients with disorders other than mental disease;

- Is licensed and formally approved as a hospital by an officially designated authority for State standard setting;

- Meets the requirements for participation in Medicare (again, except in the case of medical supervision of nurse midwife services per 42 CFR 440.165); and

- Has in effect a utilization review plan (that meets the requirements in 42 CFR 482.30) applicable to all Medicaid patients, unless a waiver has been granted by the Secretary.

NOTE: Inpatient hospital services do not include NF services furnished by a hospital with a swing bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separate from the general hospital.

ICF Services For The Mentally Retarded - 42 CFR 440.150(c)

These may include services provided in an institution for the mentally retarded or persons with related conditions if:

o The primary purpose of the institution is to provide health or rehabilitative services to such individuals;

o The institution meets the standards in 42 CFR 443.75(b) (Intermediate Care Facility Requirements; All Facilities) and 42 CFR 483, Subpart D (Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded); and

o The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 483.440.

NF Services - §1919(a) of the Act

These are services provided in a facility that:

o Is primarily engaged in providing to residents:

- Skilled nursing care and related services for residents who require medical or nursing care,

- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

- On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and

- Is not primarily for the care and treatment of mental diseases.

o Has in effect a transfer agreement (meeting the requirements of §1861(l) of the Act, with one or more hospitals having agreements in effect under §1866; and

o Meets the requirements for a nursing facility described in §1919(b), (c) and (d) of the Act.

Such terms also includes any facility which is located in a State or on an Indian reservation and is certified by the Secretary as meeting the requirements of §1919(a)(1), and §1919 (b), (c), and (d) of the Act.

Mental Health NF Services for the Aged - 42 CFR 440.140(b) and (c)

These are services defined in 42 CFR 440.40(a) and in 42 CFR 440.150 and which are provided in an institution for mental disease to recipients determined to be in need of such services.

Physician's Services - 42 CFR 440.50

These are services furnished in the office, the recipient's home, a hospital, a NF, or elsewhere, and which are provided:

o Within the scope of practice of medicine or osteopathy as defined by State law; and

o By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

NOTE: For statistical purposes, exclude all such services that are provided by and billed for by the hospital, clinic, or laboratory. Include services provided by and billed by a physician under physician services with the exception of lab and X-ray services. Include such services provided by and billed for by a physician under the lab and X-ray services category.

Outpatient Hospital Services - 42 CFR 440.20(a)

These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

o Are furnished to outpatients;

o Except in the case of nurse midwife services (see 42 CFR 440.165), are furnished by or under the direction of a physician or dentist; and

o Are furnished by an institution that:

- Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and

- Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165) meets the requirements for participation in Medicare.

Clinic Services - 42 CFR 440.90

These are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

o Are provided to outpatients;

o Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. It may be a group of physicians who share space, services of support staff, etc., for mutual convenience only. They are considered physicians for reporting purposes, rather than a clinic, even though they practice under the name of clinic; and

o Except in the case of nurse midwife services (see 42 CFR 440.165), are furnished by or under the direction of a physician.

NOTE: Place dental clinics under all other acute care services. A clinic staff may include practitioners with different specialties.

Laboratory and X-ray Services - 42 CFR 440.30

These are professional or technical laboratory and radiological services:

o Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of his/her practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory;

o Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and

o Provided by a laboratory that meets the requirements for participation in Medicare.

NOTE: Report X-rays by dentists under the all other acute care services category.

Prescribed Drugs - 42 CFR 440.120(a)

These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

o Prescribed by a physician or other licensed practitioner within the scope of his/her professional practice as defined and limited by Federal and State law;

o Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

o Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

NOTE: For statistical reporting purposes, prescribed drugs are those dispensed by licensed pharmacists only.

All Other Acute Care Services

Dental Services - 42 CFR 440.100

These are services that are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his/her profession, including treatment of:

o The teeth and associated structures of the oral cavity; and

o Disease, injury or an impairment that may affect the oral or general health of that recipient.

A dentist is an individual licensed to practice dentistry or dental surgery.

NOTE: For statistical purposes, exclude all services provided as part of inpatient hospital, outpatient hospital, clinic or laboratory services and billed for by the hospital, non-dental clinic, or laboratory. Include dental screening and dental clinics as dental services.

Other Licensed Practitioners' Services - 42 CFR 440.60

These are any medical or remedial care or service:

o Other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. Examples of other practitioners (if covered under State law) include:

- Chiropractors;
- Professional nurses;
- Podiatrists;
- Psychologists;
- Optometrists; and
- Christian Science Practitioners, and

o With certain exceptions:

- Services of professional nurses include private duty nursing services as defined in 42 CFR 440.80 when recognized in the State plan;

- If services of other practitioners are billed by a hospital, consider them as inpatient or outpatient services, as applicable;

- If eyeglasses or hearing aids are billed by a physician, include them under physician services; otherwise, include them under all other acute care services; and

- Include speech therapists, audiologists, opticians, physical therapists and occupational therapists under all other acute care.

NOTE: Chiropractor services include only services provided by a chiropractor (who is licensed by the State and meets standards issued by the Secretary in 42 CFR 405.232(b)) and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

Family Planning Services - 42 CFR 440.40(c)

These include:

o Consultation (including counseling and patient education), examination, and treatment, furnished by, or under, the supervision of a physician or prescribed by a physician;

o Laboratory examination;

o Medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception;

o Natural family planning methods;

o Diagnosis and treatment for infertility; and

o Voluntary sterilizations and drugs.

NOTE: This includes only services matched at 90%.

Early and Periodic Screening - 42 CFR 440.40(b)

These include the physical and mental assessment given to Medicaid eligibles under the age of 21 to carry out the screening provisions of the EPSDT program.

However, the agency must provide for at least the following services through consultation with health experts, and must determine the specific health evaluation procedures to use and the mechanisms needed to carry out the screening program:

- o Health and developmental history;
- o Unclothed physical examination;
- o Developmental assessment;
- o Immunizations which are appropriate for age and health history;
- o Assessment of nutritional status;
- o Vision testing;
- o Hearing testing;
- o Laboratory procedures appropriate for age and population groups; and
- o For children 3 years of age and over, dental services furnished by direct referral to a dentist for diagnosis and treatment.

The above assessments may be done on a group basis in a clinic or by individual practitioners in their office.

Other Care - 42 CFR 440.170

These include any medical or remedial care recognized under State law and specified by the Secretary. Such services do not meet the definition of and are not classifiable under any of the aforementioned 42 CFR 440 categories. They may include, but are not limited to:

A. Transportation.--Includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined above, is furnished only by providers to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation (see 42 CFR 431.53), Federal Financial Participation is available as an administrative cost.

B. Physical Therapy.--Services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. (See 42 CFR 440.110(a)(2).) It includes any necessary supplies and equipment.

C. Occupational Therapy.--Services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational

therapist. (See 42 CFR 440.110(b)(2).) It includes any necessary supplies and equipment.

D. Services for Individuals with Speech, Hearing, and Language Disorders (also see Other Licensed Practitioners Services).--Diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist (see 42 CFR 440.110(c)(2)), for which a patient is referred by a physician. It includes any necessary supplies and equipment.

E. Dentures, Prosthetic Devices, and Eyeglasses (also see "Other Licensed Practitioners Services").--Dentures are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth. (See 42 CFR 440.120(b).) Prosthetic devices are replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law to:

- o Artificially replace a missing portion of the body;
- o Prevent or correct physical deformity or malfunctions; or
- o Support a weak or deformed portion of the body.

NOTE: Include all durable medical equipment under this category.

Eyeglasses are lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye, an optometrist or an optician. Also includes optician fees for services. (See 42 CFR 440.120(d).)

F. Diagnostic, Screening, Preventive and Rehabilitative Services.--Diagnostic services, except as otherwise provided in 42 CFR 440, include any medical procedures or supplies recommended by a physician or other licensed practitioner within the scope of his or her practice under State law, in order to identify the existence, nature or extent of illness, injury, or other health deviation in a recipient. (See 42 CFR 440.130(a).)

Screening services mean the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, or to identify for more definitive studies individuals suspected of having certain diseases. (See 42 CFR 440.130(b).)

Preventive services mean services provided by a physician or other licensed practitioner within the scope of his or her practice under State law to:

- o Prevent disease, disability, and other health conditions or their progression;
- o Prolong life; and
- o Promote physical and mental health and efficiency.

Rehabilitative services, except as otherwise provided in 42 CFR 440, include any medical or remedial services recommended by a physician or other licensed practitioner, within the scope of his or her practice under State law,

for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level. (See 42 CFR 440.130(d).)

NOTE: Include nurse midwife services under inpatient hospital, outpatient hospital, or all other acute care depending upon how the services were billed. Also include emergency hospital services under various reporting categories depending upon how the services were billed.

G. Rural Health Clinic Services(42 CFR 440.20(b)).--If you permit the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic services are the following services when furnished by a rural health clinic that has been certified in accordance with the conditions of 42 CFR 491:

o Services furnished by a physician within the scope of his/her profession under State law, if the physician performs these services in the clinic or the services are furnished away from the clinic and the physician has an agreement with the clinic providing that he or she will be paid by it for such services.

o Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 42 CFR 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2414(a).

o Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 42 CFR 405.2415 for the criteria to determine whether services and supplies are included here.)

o Part time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

- The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see 42 CFR 405.2417);

- The services are furnished by an RN or LPN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic;

- The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

- The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient is one who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. He/she may be considered homebound if he/she leaves the place of residency infrequently. For this purpose, place of residence does not include a hospital or an NF.

H. Mental Hospital Services for the Aged.--Refers to inpatient hospital services for individuals aged 65 or older, provided under the direction of a physician for the care and treatment of recipients in an institution for mental
diseases that meets the requirements specified in 42 CFR 482.60(b), (c),

and(e), and meets the requirements for utilization review in 42 CFR 482.30(a), (b), (d), and (e), or has been granted a waiver of those requirements. (See 42 CFR 440.140(a).)

I. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under (see 42 CFR 440.160).--Are those services that:

o Are provided under the direction of a physician;

o Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Hospitals; and

o Meet the requirements set in 42 CFR 441 (d) (Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs).

J. Optional Targeted Case Management Services.--Services are provided under §1915(g)(1) of the Act to assist individuals eligible for Medicaid in gaining access to needed medical, social, educational, and other services, to encourage the use of cost effective medical care by referrals to appropriate providers, and to discourage overutilization of costly services, such as emergency room care for routine procedures.

NOTE: Case management may also be provided as a home and community-based waiver service or as an integral part of an otherwise covered Medicaid service.

Include services necessary to avoid recipient institutionalization which were approved as cost effective by HCFA. These include but are not limited to nursing care, medical equipment and supplies, physical and occupational therapy, speech pathology and audiology, and minor physical adaptations to the home.

K. Adult Day Health Services.--These include health and social services needed to insure the recipient's optimal functioning.

L. Home Health Services(42 CFR 440.70).--These include the following services and items:

o Nursing service, as defined in the State Nurse Practice Act, that is provided on a part time or intermittent basis by a HHA that meets the requirements for participation in Medicare or if there is no agency in the area, is provided by a registered nurse who:

- Is currently licensed to practice in the State;
- Receives written orders from the patient's physician;
- Documents the care and services provided; and
- Has had orientation on acceptable clinical and administrative recordkeeping from a health department nurse;

o Home health aide services provided by a home health agency;

o Medical supplies, equipment, and appliances suitable for use in the home; and

o Physical therapy, occupational therapy, or speech pathology and audiology services provided by a HHA or by a facility licensed by the State to provide medical rehabilitation services. (See 42 CFR 441.15 - Home Health Services.)

These services are provided to a recipient:

o At his or her place of residence (does not include a hospital, NF, or ICF except for home health services in an ICF that are not required to be provided by the facility under 42 CFR 442 (f) and (g). For example, an RN may provide short term care for a recipient in an ICF during an acute illness to avoid the recipient's transfer to an SNF; and

o On his/her physician's orders, as part of a written plan of care, that the physician reviews every 60 days.

NOTE: Form HCFA-2082 home health category includes home health services, personal care services and home and community-based waiver services. For Form HCFA-372 reporting, only State plan provided home health services are included here.

M. Personal Care Services - 42 CFR 440.170(f).--These are services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is:

- o Qualified to provide the services;
- o Supervised by a registered nurse; and
- o Not a member of the recipient's family.